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FAQs on Preventive Care Services

New Frequently Asked Questions (FAQs) provide more details on compliance with preventive service recommendations, which the healthcare reform law requires all non-grandfathered plans to adopt by the first plan year that starts one year after any new recommendation. The healthcare reform law requires non-grandfathered group health plans to cover preventive care services (such as mammograms, colonoscopies and immunizations) without cost-sharing. The coverage offered must be consistent with published recommendations and guidelines from the United States Preventive Services Task Force (USPSTF), the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA).

Out-of-Network Preventive Services: Generally, group health plans are not required to cover recommended preventive services out-of-network. The FAQs provide, however, that if a plan does not have an in-network provider who can provide a particular recommended preventive service, the plan must cover the service when provided by an out-of-network provider without cost-sharing.

US Preventive Services Task Force (USPSTF) Recommendations: The law requires that group health plans cover, without cost-sharing, preventive services with an A or B rating from the USPSTF.

- *Aspirin.* The USPSTF recommends aspirin for adults to prevent cardiovascular disease under some circumstances. The FAQs state that plans must cover, without cost-sharing, aspirin and other over the-counter recommended items and services only when prescribed by a healthcare provider.
- *Colonoscopy/Unplanned Polyp Removal.* Plans cannot impose cost-sharing for the cost of polyp removal during a colonoscopy that is performed as a screening procedure pursuant to the USPSTF recommendation.
- *Genetic Testing/Counseling for Breast Cancer.* The USPSTF's recommendation for genetic counseling and evaluation for routine breast cancer susceptibility gene (BRCA) testing includes the BRCA test. Therefore, plans must cover, without cost-sharing, genetic counseling and BRCA testing, if appropriate.

More Details on Women's Preventive Services Coverage Requirement: The law requires that group health plans cover, without cost-sharing, women's preventive services supported by Health Resources and Services Administration (HRSA) guidelines.

Multiple Visits. Group health plans can use reasonable medical management techniques to require multiple prevention and screening services at a single visit. HRSA Guidelines do not require multiple visits for separate services.

- *Well Woman Visits.* HRSA guidelines recommend at least 1 annual well-woman preventive care visit. However, if clinicians determine that patients require additional well-woman visits to obtain all necessary recommended preventive services, plans must cover those additional visits without cost-sharing, subject to reasonable medical management.
- *HPV Testing.* HRSA guidelines recommend high-risk Human Papillomavirus (HPV) DNA testing for women with normal cytology results who are 30 or older no more frequently than every 3 years.
- *Contraceptive Methods.* Plans can use reasonable medical management techniques with respect to coverage of FDA-approved contraceptive methods. For example, plans can cover a generic drug without cost-sharing and require cost-sharing for equivalent branded drugs. However, plans must have a mechanism for waiving otherwise applicable cost-sharing when healthcare providers determine that the certain drug (with required cost-sharing) is medically appropriate.
- *OTC Contraceptives.* Plans do not have to cover contraceptive methods that are generally available over-the-counter (e.g., sponges and spermicides) unless they are prescribed by a healthcare provider. Plans do not have to cover contraception for men (e.g., condoms and vasectomies).
- *Side Effects, Removal and Counseling.* Plans must cover, without cost-sharing (subject to reasonable medical management), services related to follow-up and management of side effects, counseling for continued adherence, and device removal.
- *Intrauterine devices and implants.* Plans must cover, without cost-sharing, intrauterine devices and implants if they are approved by the FDA and prescribed by a healthcare provider, subject to reasonable medical management.
- *Breastfeeding.* HRSA guidelines include coverage for lactation support and counseling and costs of renting or purchasing breastfeeding equipment—for the duration of breastfeeding. However, plans can use reasonable medical management techniques to determine frequency, method, treatment, or setting with respect to lactation counseling and breastfeeding equipment and supplies under HRSA guidelines.

Advisory Committee on Immunization Practices (ACIP) Recommendations

- *Vaccination.* In some circumstances, the ACIP makes a vaccine recommendation for certain individuals rather than an entire population. In these circumstances, if health care providers prescribe a vaccine consistent with ACIP recommendations, plans must cover the vaccine without cost-sharing.

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